26-21-1. Title.

This chapter is known as the "Health Care Facility Licensing and Inspection Act."

Amended by Chapter 209, 1997 General Session

26-21-2. Definitions.

As used in this chapter:

(1) "Abortion clinic" means a type I abortion clinic or a type II abortion clinic.

(2) "Activities of daily living" means essential activities including:

(a) dressing;

(b) eating;

(c) grooming;

(d) bathing;

(e) toileting;

(f) ambulation;

(g) transferring; and

(h) self-administration of medication.

(3) "Ambulatory surgical facility" means a freestanding facility, which provides surgical services to patients not requiring hospitalization.

(4) "Assistance with activities of daily living" means providing of or arranging for the provision of assistance with activities of daily living.

(5) (a) "Assisted living facility" means:

(i) a type I assisted living facility, which is a residential facility that provides assistance with activities of daily living and social care to two or more residents who:

(A) require protected living arrangements; and

(B) are capable of achieving mobility sufficient to exit the facility without the assistance of another person; and

(ii) a type II assisted living facility, which is a residential facility with a home-like setting that provides an array of coordinated supportive personal and health care services available 24 hours per day to residents who have been assessed under department rule to need any of these services.

(b) Each resident in a type I or type II assisted living facility shall have a service plan based on the assessment, which may include:

(i) specified services of intermittent nursing care;

(ii) administration of medication; and

(iii) support services promoting residents' independence and self sufficiency.

(6) "Birthing center" means a freestanding facility, receiving maternal clients and providing care during pregnancy, delivery, and immediately after delivery.

(7) "Committee" means the Health Facility Committee created in Section 26-1-7.

(8) "Consumer" means any person not primarily engaged in the provision of health care to individuals or in the administration of facilities or institutions in which such care is provided and who does not hold a fiduciary position, or have a fiduciary interest in any entity involved in the provision of health care, and does not receive, either directly or through his spouse, more than 1/10 of his gross income from any entity or activity relating to health care.

(9) "End stage renal disease facility" means a facility which furnishes

staff-assisted kidney dialysis services, self-dialysis services, or home-dialysis services on an outpatient basis.

(10) "Freestanding" means existing independently or physically separated from another health care facility by fire walls and doors and administrated by separate staff with separate records.

(11) "General acute hospital" means a facility which provides diagnostic, therapeutic, and rehabilitative services to both inpatients and outpatients by or under the supervision of physicians.

(12) "Governmental unit" means the state, or any county, municipality, or other political subdivision or any department, division, board, or agency of the state, a county, municipality, or other political subdivision.

(13) (a) "Health care facility" means general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, residential-assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, abortion clinics, facilities owned or operated by health maintenance organizations, end stage renal disease facilities, and any other health care facility which the committee designates by rule.

(b) "Health care facility" does not include the offices of private physicians or dentists, whether for individual or group practice, except that it does include an abortion clinic.

(14) "Health maintenance organization" means an organization, organized under the laws of any state which:

(a) is a qualified health maintenance organization under 42 U.S.C. Sec. 300e-9; or

(b) (i) provides or otherwise makes available to enrolled participants at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency, and preventive services and out-of-area coverage;

(ii) is compensated, except for copayments, for the provision of the basic health services listed in Subsection (14)(b)(i) to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health services are provided and which is fixed without regard to the frequency, extent, or kind of health services actually provided; and

(iii) provides physicians' services primarily directly through physicians who are either employees or partners of such organizations, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(15) (a) "Home health agency" means an agency, organization, or facility or a subdivision of an agency, organization, or facility which employs two or more direct care staff persons who provide licensed nursing services, therapeutic services of physical therapy, speech therapy, occupational therapy, medical social services, or home health aide services on a visiting basis.

(b) "Home health agency" does not mean an individual who provides services under the authority of a private license.

(16) "Hospice" means a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, and supportive care and treatment.

(17) "Nursing care facility" means a health care facility, other than a general acute or specialty hospital, constructed, licensed, and operated to provide patient living accommodations, 24-hour staff availability, and at least two of the following patient services:

(a) a selection of patient care services, under the direction and supervision of a registered nurse, ranging from continuous medical, skilled nursing, psychological, or other professional therapies to intermittent health-related or paraprofessional personal care services;

(b) a structured, supportive social living environment based on a professionally designed and supervised treatment plan, oriented to the individual's habilitation or rehabilitation needs; or

(c) a supervised living environment that provides support, training, or assistance with individual activities of daily living.

(18) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(19) "Resident" means a person 21 years of age or older who:

(a) as a result of physical or mental limitations or age requires or requests services provided in an assisted living facility; and

(b) does not require intensive medical or nursing services as provided in a hospital or nursing care facility.

(20) "Small health care facility" means a four to 16 bed facility that provides licensed health care programs and services to residents.

(21) "Specialty hospital" means a facility which provides specialized diagnostic, therapeutic, or rehabilitative services in the recognized specialty or specialties for which the hospital is licensed.

(22) "Substantial compliance" means in a department survey of a licensee, the department determines there is an absence of deficiencies which would harm the physical health, mental health, safety, or welfare of patients or residents of a licensee.

(23) "Type I abortion clinic" means a facility, including a physician's office, but not including a general acute or specialty hospital, that:

(a) performs abortions, as defined in Section 76-7-301, during the first trimester of pregnancy; and

(b) does not perform abortions, as defined in Section 76-7-301, after the first trimester of pregnancy.

(24) "Type II abortion clinic" means a facility, including a physician's office, but not including a general acute or specialty hospital, that:

(a) performs abortions, as defined in Section 76-7-301, after the first trimester of pregnancy; or

(b) performs abortions, as defined in Section 76-7-301, during the first trimester of pregnancy and after the first trimester of pregnancy.

Amended by Chapter 161, 2011 General Session

26-21-2.1. Services.

(1) General acute hospitals and specialty hospitals shall remain open and be continuously ready to receive patients 24 hours of every day in a year and have an

attending medical staff consisting of one or more physicians licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(2) A specialty hospital shall provide on-site all basic services required of a general acute hospital that are needed for the diagnosis, therapy, or rehabilitation offered to or required by patients admitted to or cared for in the facility.

(3) (a) A home health agency shall provide at least licensed nursing services or therapeutic services directly through the agency employees.

(b) A home health agency may provide additional services itself or under arrangements with another agency, organization, facility, or individual.

Amended by Chapter 209, 1997 General Session

26-21-3. Health Facility Committee -- Members -- Terms -- Organization -- Meetings.

(1) The Health Facility Committee created by Section 26-1-7 consists of 15 members appointed by the governor with the consent of the Senate. The appointed members shall be knowledgeable about health care facilities and issues. The membership of the committee is:

(a) one physician, licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, who is a graduate of a regularly chartered medical school;

(b) one hospital administrator;

(c) one hospital trustee;

(d) one representative of a freestanding ambulatory surgical facility;

(e) one representative of an ambulatory surgical facility that is affiliated with a hospital;

(f) two representatives of the nursing care facility industry;

(g) one registered nurse, licensed to practice under Title 58, Chapter 31b, Nurse Practice Act;

(h) one professional in the field of intellectual disabilities not affiliated with a nursing care facility;

(i) one licensed architect or engineer with expertise in health care facilities;

(j) two representatives of assisted living facilities licensed under this chapter;

(k) two consumers, one of whom has an interest in or expertise in geriatric care; and

(l) one representative from either a home health care provider or a hospice provider.

(2) (a) Except as required by Subsection (2)(b), members shall be appointed for a term of four years.

(b) Notwithstanding the requirements of Subsection (2)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the committee is appointed every two years.

(c) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term by the governor, giving consideration to

recommendations made by the committee, with the consent of the Senate.

(d) A member may not serve more than two consecutive full terms or 10 consecutive years, whichever is less. However, a member may continue to serve as a member until he is replaced.

(e) The committee shall annually elect from its membership a chair and vice chair.

(f) The committee shall meet at least quarterly, or more frequently as determined by the chair or five members of the committee.

(g) Eight members constitute a quorum. A vote of the majority of the members present constitutes action of the committee.

Amended by Chapter 366, 2011 General Session

26-21-4. Per diem and travel expenses of committee members.

A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(1) Section 63A-3-106;

(2) Section 63A-3-107; and

(3) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Amended by Chapter 286, 2010 General Session

26-21-5. Duties of committee.

The committee shall:

(1) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(a) for the licensing of health-care facilities; and

(b) requiring the submission of architectural plans and specifications for any proposed new health-care facility or renovation to the department for review;

(2) approve the information for applications for licensure pursuant to Section 26-21-9;

(3) advise the department as requested concerning the interpretation and enforcement of the rules established under this chapter; and

(4) advise, consult, cooperate with, and provide technical assistance to other agencies of the state and federal government, and other states and affected groups or persons in carrying out the purposes of this chapter.

Amended by Chapter 382, 2008 General Session

26-21-6. Duties of department.

(1) The department shall:

(a) enforce rules established pursuant to this chapter;

(b) authorize an agent of the department to conduct inspections of health care facilities pursuant to this chapter;

(c) collect information authorized by the committee that may be necessary to

ensure that adequate health care facilities are available to the public;

(d) collect and credit fees for licenses as free revenue;

(e) collect and credit fees for conducting plan reviews as dedicated credits;

(f) (i) collect and credit fees for conducting clearance under Chapter 21, Part 2, Clearance for Direct Patient Access; and

(ii) beginning July 1, 2012:

(A) up to $105,000 of the fees collected under Subsection (1)(f)(i) are dedicated credits; and

(B) the fees collected for background checks under Subsection 26-21-204(6) and Section 26-21-205 shall be transferred to the Department of Public Safety to reimburse the Department of Public Safety for its costs in conducting the federal background checks;

(g) designate an executive secretary from within the department to assist the committee in carrying out its powers and responsibilities;

(h) establish reasonable standards for criminal background checks by public and private entities;

(i) recognize those public and private entities that meet the standards established pursuant to Subsection (1)(h); and

(j) provide necessary administrative and staff support to the committee.

(2) The department may:

(a) exercise all incidental powers necessary to carry out the purposes of this chapter;

(b) review architectural plans and specifications of proposed health care facilities or renovations of health care facilities to ensure that the plans and specifications conform to rules established by the committee; and

(c) make rules as necessary to implement the provisions of this chapter, except as authority is specifically delegated to the committee.

Amended by Chapter 328, 2012 General Session

26-21-6.5. Licensing of an abortion clinic -- Rulemaking authority -- Fee.

(1) Beginning on April 1, 2012, a type I abortion clinic may not operate in the state without a license issued by the department to operate a type I abortion clinic.

(2) A type II abortion clinic may not operate in the state without a license issued by the department to operate a type II abortion clinic.

(3) (a) The department shall make rules establishing minimum health, safety, sanitary, and recordkeeping requirements for:

(i) a type I abortion clinic; and

(ii) a type II abortion clinic.

(b) The rules established under Subsection (3)(a) shall take effect on April 1, 2012.

(4) Beginning on April 1, 2012, in order to receive and maintain a license described in this section, an abortion clinic shall:

(a) apply for a license on a form prescribed by the department;

(b) satisfy and maintain the minimum health, safety, sanitary, and recordkeeping requirements established under Subsection (3)(a) that relate to the type of abortion

clinic licensed;

(c) comply with the recordkeeping and reporting requirements of Subsection 76-7-305.6(4) and Section 76-7-313;

(d) comply with the requirements of Title 76, Chapter 7, Part 3, Abortion;

(e) pay the annual licensing fee; and

(f) cooperate with inspections conducted by the department.

(5) Beginning on April 1, 2012, the department shall, at least twice per year, inspect each abortion clinic in the state to ensure that the abortion clinic is complying with all statutory and licensing requirements relating to the abortion clinic. At least one of the inspections shall be made without providing notice to the abortion clinic.

(6) Beginning on April 1, 2012, the department shall charge an annual license fee, set by the department in accordance with the procedures described in Section 63J-1-504, to an abortion clinic in an amount that will pay for the cost of the licensing requirements described in this section and the cost of inspecting abortion clinics.

(7) The department shall deposit the licensing fees described in this section in the General Fund as a dedicated credit to be used solely to pay for the cost of the licensing requirements described in this section and the cost of inspecting abortion clinics.

Enacted by Chapter 161, 2011 General Session

26-21-7. Exempt facilities.

This chapter does not apply to:

(1) a dispensary or first aid facility maintained by any commercial or industrial plant, educational institution, or convent;

(2) a health care facility owned or operated by an agency of the United States;

(3) the office of a physician or dentist whether it is an individual or group practice, except that it does apply to an abortion clinic;

(4) a health care facility established or operated by any recognized church or denomination for the practice of religious tenets administered by mental or spiritual means without the use of drugs, whether gratuitously or for compensation, if it complies with statutes and rules on environmental protection and life safety;

(5) any health care facility owned or operated by the Department of Corrections, created in Section 64-13-2; and

(6) a residential facility providing 24-hour care:

(a) that does not employ direct care staff;

(b) in which the residents of the facility contract with a licensed hospice agency to receive end-of-life medical care; and

(c) that meets other requirements for an exemption as designated by administrative rule.

Amended by Chapter 161, 2011 General Session

26-21-8. License required -- Not assignable or transferable -- Posting -- Expiration and renewal -- Time for compliance by operating facilities.

(1) (a) A person or governmental unit acting severally or jointly with any other

person or governmental unit, may not establish, conduct, or maintain a health care facility in this state without receiving a license from the department as provided by this chapter and the rules of the committee.

(b) This Subsection (1) does not apply to facilities that are exempt under Section 26-21-7.

(2) A license issued under this chapter is not assignable or transferable.

(3) The current license shall at all times be posted in each health care facility in a place readily visible and accessible to the public.

(4) (a) The department may issue a license for a period of time not to exceed 12 months from the date of issuance for an abortion clinic and not to exceed 24 months from the date of issuance for other health care facilities that meet the provisions of this chapter and department rules adopted pursuant to this chapter.

(b) Each license expires at midnight on the day designated on the license as the expiration date, unless previously revoked by the department.

(c) The license shall be renewed upon completion of the application requirements, unless the department finds the health care facility has not complied with the provisions of this chapter or the rules adopted pursuant to this chapter.

(5) A license may be issued under this section only for the operation of a specific facility at a specific site by a specific person.

(6) Any health care facility in operation at the time of adoption of any applicable rules as provided under this chapter shall be given a reasonable time for compliance as determined by the committee.

Amended by Chapter 161, 2011 General Session

26-21-9. Application for license -- Information required -- Public records.

(1) An application for license shall be made to the department in a form prescribed by the department. The application and other documentation requested by the department as part of the application process shall require such information as the committee determines necessary to ensure compliance with established rules.

(2) Information received by the department in reports and inspections shall be public records, except the information may not be disclosed if it directly or indirectly identifies any individual other than the owner or operator of a health facility (unless disclosure is required by law) or if its disclosure would otherwise constitute an unwarranted invasion of personal privacy.

(3) Information received by the department from a health care facility, pertaining to that facility's accreditation by a voluntary accrediting organization, shall be private data except for a summary prepared by the department related to licensure standards.

Amended by Chapter 297, 2011 General Session

26-21-11. Violations -- Denial or revocation of license -- Restricting or prohibiting new admissions -- Monitor.

If the department finds a violation of this chapter or any rules adopted pursuant to this chapter the department may take one or more of the following actions:

(1) serve a written statement of violation requiring corrective action, which shall

include time frames for correction of all violations;

(2) deny or revoke a license if it finds:

(a) there has been a failure to comply with the rules established pursuant to this chapter;

(b) evidence of aiding, abetting, or permitting the commission of any illegal act; or

(c) conduct adverse to the public health, morals, welfare, and safety of the people of the state;

(3) restrict or prohibit new admissions to a health care facility or revoke the license of a health care facility for:

(a) violation of any rule adopted under this chapter; or

(b) permitting, aiding, or abetting the commission of any illegal act in the health care facility;

(4) place a department representative as a monitor in the facility until corrective action is completed;

(5) assess to the facility the cost incurred by the department in placing a monitor;

(6) assess an administrative penalty as allowed by Subsection 26-23-6(1)(a); or

(7) issue a cease and desist order to the facility.

Amended by Chapter 209, 1997 General Session

26-21-12. Issuance of new license after revocation -- Restoration.

(1) If a license is revoked, the department may issue a new license only after it determines by inspection that the facility has corrected the conditions that were the basis of revocation and that the facility complies with all provisions of this chapter and applicable rules.

(2) If the department does not renew a license because of noncompliance with the provisions of this chapter or the rules adopted under this chapter, the department may issue a new license only after the facility complies with all renewal requirements and the department determines that the interests of the public will not be jeopardized.

Amended by Chapter 209, 1997 General Session

26-21-13. License issued to facility in compliance or substantial compliance with chapter and rules.

(1) The department shall issue a standard license for a health care facility which is found to be in compliance with the provisions of this chapter and with all applicable rules adopted by the committee.

(2) The department may issue a provisional or conditional license for a health care facility which is in substantial compliance if the interests of the public will not be jeopardized.

Amended by Chapter 114, 1990 General Session

26-21-13.5. Intermediate care facilities for people with an intellectual disability -- Licensing.

(1) (a) It is the Legislature's intent that a person with a developmental disability be provided with an environment and surrounding that, as closely as possible, resembles small community-based, homelike settings, to allow those persons to have the opportunity, to the maximum extent feasible, to exercise their full rights and responsibilities as citizens.

(b) It is the Legislature's purpose, in enacting this section, to provide assistance and opportunities to enable a person with a developmental disability to achieve the person's maximum potential through increased independence, productivity, and integration into the community.

(2) After July 1, 1990, the department may only license intermediate care beds for people with an intellectual disability in small health care facilities.

(3) The department may define by rule "small health care facility" for purposes of licensure under this section and adopt rules necessary to carry out the requirements and purposes of this section.

(4) This section does not apply to the renewal of a license or the licensure to a new owner of any facility that was licensed on or before July 1, 1990, and that licensure has been maintained without interruption.

Amended by Chapter 366, 2011 General Session

26-21-13.6. Rural hospital -- Optional service designation.

(1) The Legislature finds that:

(a) the rural citizens of this state need access to hospitals and primary care clinics;

(b) financial stability of remote-rural hospitals and their integration into remote-rural delivery networks is critical to ensure the continued viability of remote-rural health care; and

(c) administrative simplicity is essential for providing large benefits to small-scale remote-rural providers who have limited time and resources.

(2) After July 1, 1995, the department may grant variances to remote-rural acute care hospitals for specific services currently required for licensure under general hospital standards established by department rule.

(3) For purposes of this section, "remote-rural hospitals" are hospitals that are in a county with less than 20 people per square mile.

Enacted by Chapter 321, 1995 General Session

26-21-14. Closing facility -- Appeal.

(1) If the department finds a condition in any licensed health care facility that is a clear hazard to the public health, the department may immediately order that facility closed and may prevent the entrance of any resident or patient onto the premises of that facility until the condition is eliminated.

(2) Parties aggrieved by the actions of the department under this section may obtain an adjudicative proceeding and judicial review.

Amended by Chapter 114, 1990 General Session

26-21-15. Action by department for injunction.

Notwithstanding the existence of any other remedy, the department may, in the manner provided by law, upon the advice of the attorney general, who shall represent the department in the proceedings, maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of a health care facility which is in violation of this chapter or rules adopted by the committee.

Amended by Chapter 114, 1990 General Session

26-21-16. Operating facility in violation of chapter a misdemeanor.

In addition to the penalties in Section 26-23-6, any person owning, establishing, conducting, maintaining, managing, or operating a health care facility in violation of this chapter is guilty of a class A misdemeanor.

Amended by Chapter 347, 2009 General Session

26-21-17. Department agency of state to contract for certification of facilities under Social Security Act.

The department is the sole agency of the state authorized to enter into a contract with the United States government for the certification of health care facilities under Title XVIII and Title XIX of the Social Security Act, and any amendments thereto.

Amended by Chapter 114, 1990 General Session

26-21-19. Life and Health Insurance Guaranty Association Act not amended.

The provisions of this chapter do not amend, affect, or alter the provisions of Title 31A, Chapter 28.

Amended by Chapter 242, 1985 General Session

26-21-20. Requirement for hospitals to provide statements of itemized charges to patients.

(1) For purposes of this section, "hospital" includes:

(a) an ambulatory surgical facility;

(b) a general acute hospital; and

(c) a specialty hospital.

(2) A hospital shall provide a statement of itemized charges to any patient receiving medical care or other services from that hospital.

(3) (a) The statement shall be provided to the patient or the patient's personal representative or agent at the hospital's expense, personally, by mail, or by verifiable electronic delivery after the hospital receives an explanation of benefits from a third party payer which indicates the patient's remaining responsibility for the hospital charges.

(b) If the statement is not provided to a third party, it shall be provided to the

patient as soon as possible and practicable.

(4) The statement required by this section:

(a) shall itemize each of the charges actually provided by the hospital to the patient;

(b) (i) shall include the words in bold "THIS IS THE BALANCE DUE AFTER PAYMENT FROM YOUR HEALTH INSURER"; or

(ii) shall include other appropriate language if the statement is sent to the patient under Subsection (3)(b); and

(c) may not include charges of physicians who bill separately.

(5) The requirements of this section do not apply to patients who receive services from a hospital under Title XIX of the Social Security Act.

(6) Nothing in this section prohibits a hospital from sending an itemized billing statement to a patient before the hospital has received an explanation of benefits from an insurer. If a hospital provides a statement of itemized charges to a patient prior to receiving the explanation of benefits from an insurer, the itemized statement shall be marked in bold: "DUPLICATE: DO NOT PAY" or other appropriate language.

Amended by Chapter 11, 2009 General Session

26-21-21. Authentication of medical records.

Any entry in a medical record compiled or maintained by a health care facility may be authenticated by identifying the author of the entry by:

(1) a signature including first initial, last name, and discipline; or

(2) the use of a computer identification process unique to the author that definitively identifies the author.

Enacted by Chapter 31, 1992 General Session

26-21-22. Reporting of disciplinary information -- Immunity from liability.

A health care facility licensed under this chapter which reports disciplinary information on a licensed nurse to the Division of Occupational and Professional Licensing within the Department of Commerce as required by Section 58-31b-702 is entitled to the immunity from liability provided by that section.

Enacted by Chapter 288, 1998 General Session

26-21-23. Licensing of non-Medicaid nursing care facility beds.

(1) Notwithstanding the provisions of Section 26-21-2, for purposes of this section "nursing care facility" and "small health care facility":

(a) mean the following facilities licensed by the department under this chapter:

(i) skilled nursing homes;

(ii) intermediate care facilities; or

(iii) small health care facilities with four to 16 beds functioning as a skilled nursing home; and

(b) does not mean:

(i) an intermediate care facility for the mentally retarded;

(ii) a critical access hospital that meets the criteria of 42 U.S.C. 1395i-4(c)(2) (1998);

(iii) a small health care facility that is hospital based; or

(iv) a small health care facility other than a skilled nursing home with 16 beds or less.

(2) Except as provided in Subsection (5), a new nursing care facility shall be approved for a health facility license only if the applicant proves to the division that:

(a) the facility will be Medicaid certified under the provisions of Section 26-18-503;

(b) the facility will have at least 100 beds; or

(c) (i) the facility's projected Medicare inpatient revenues do not exceed 49% of the facility's revenues;

(ii) the facility has identified projected non-Medicare inpatient revenue sources; and

(iii) the non-Medicare inpatient revenue sources identified in this Subsection (2)(c)(iii) will constitute at least 51% of the revenues as demonstrated through an independently certified feasibility study submitted and paid for by the facility and provided to the division.

(3) The division may not approve the addition of licensed beds in an existing nursing care facility unless the nursing care facility satisfies the criteria established in Subsection (2).

(4) The department may make rules to administer and enforce this part in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(5) The provisions of Subsection (2) do not apply to a nursing care facility that has:

(a) filed an application with the department and paid all applicable fees to the department on or before February 28, 2007; and

(b) submitted to the department the working drawings, as defined by the department by administrative rule, on or before July 1, 2008.

Amended by Chapter 60, 2013 General Session

26-21-24. Prohibition against bed banking by nursing care facilities for Medicaid reimbursement.

(1) For purposes of this section:

(a) "bed banking" means the designation of a nursing care facility bed as not part of the facility's operational bed capacity; and

(b) "nursing care facility" is as defined in Subsection 26-21-23(1).

(2) Beginning July 1, 2008, the department shall, for purposes of Medicaid reimbursement under Chapter 18, Part 1, Medical Assistance Programs, prohibit the banking of nursing care facility beds.

Enacted by Chapter 347, 2008 General Session

26-21-25. Patient identity protection.

(1) As used in this section:

(a) "EMTALA" means the federal Emergency Medical Treatment and Active Labor Act.

(b) "Health professional office" means:

(i) a physician's office; or

(ii) a dental office.

(c) "Medical facility" means:

(i) a general acute hospital;

(ii) a specialty hospital;

(iii) a home health agency;

(iv) a hospice;

(v) a nursing care facility;

(vi) a residential-assisted living facility;

(vii) a birthing center;

(viii) an ambulatory surgical facility;

(ix) a small health care facility;

(x) an abortion clinic;

(xi) a facility owned or operated by a health maintenance organization;

(xii) an end stage renal disease facility;

(xiii) a health care clinic; or

(xiv) any other health care facility that the committee designates by rule.

(2) (a) In order to discourage identity theft and health insurance fraud, and to reduce the risk of medical errors caused by incorrect medical records, a medical facility or a health professional office shall request identification from an individual prior to providing in-patient or out-patient services to the individual.

(b) If the individual who will receive services from the medical facility or a health professional office lacks the legal capacity to consent to treatment, the medical facility or a health professional office shall request identification:

(i) for the individual who lacks the legal capacity to consent to treatment; and

(ii) from the individual who consents to treatment on behalf of the individual described in Subsection (2)(b)(i).

(3) A medical facility or a health professional office:

(a) that is subject to EMTALA:

(i) may not refuse services to an individual on the basis that the individual did not provide identification when requested; and

(ii) shall post notice in its emergency department that informs a patient of the patient's right to treatment for an emergency medical condition under EMTALA;

(b) may not be penalized for failing to ask for identification;

(c) is not subject to a private right of action for failing to ask for identification; and

(d) may document or confirm patient identity by:

(i) photograph;

(ii) fingerprinting;

(iii) palm scan; or

(iv) other reasonable means.

(4) The identification described in this section:

(a) is intended to be used for medical records purposes only; and

(b) shall be kept in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996.

Amended by Chapter 218, 2010 General Session

26-21-26. General acute hospital to report prescribed controlled substance poisoning or overdose.

(1) Beginning on July 1, 2012, if a person who is 12 years of age or older is admitted to a general acute hospital for poisoning involving a prescribed controlled substance, the general acute hospital shall, within three business days after the day on which the person is admitted, send a written report to the Division of Occupational and Professional Licensing, created in Section 58-1-103, that includes:

(a) the patient's name;

(b) each drug or other substance found in the person's system that may have contributed to the poisoning or overdose, if known; and

(c) the name of each person who the general acute hospital has reason to believe may have prescribed a controlled substance described in Subsection (1)(b) to the person, if known.

(2) Nothing in this section may be construed as creating a new cause of action.

Enacted by Chapter 290, 2010 General Session

26-21-27. Consumer access to health care facility charges.

Beginning January 1, 2011, a health care facility licensed under this chapter shall, when requested by a consumer:

(1) make a list of prices charged by the facility available for the consumer that includes the facility's:

(a) in-patient procedures;

(b) out-patient procedures;

(c) the 50 most commonly prescribed drugs in the facility;

(d) imaging services; and

(e) implants; and

(2) provide the consumer with information regarding any discounts the facility provides for:

(a) charges for services not covered by insurance; or

(b) prompt payment of billed charges.

Enacted by Chapter 68, 2010 General Session

26-21-100. Reserved.

Reserved

Enacted by Chapter 328, 2012 General Session

26-21-201. Definitions.

As used in this part:

(1) "Clearance" means approval by the department under Section 26-21-203 for an individual to have direct patient access.

(2) "Covered body" means a covered provider, covered contractor, or covered employer.

(3) "Covered contractor" means a person that supplies covered individuals, by contract, to a covered employer or covered provider.

(4) "Covered employer" means an individual who:

(a) engages a covered individual to provide services in a private residence to:

(i) an aged individual, as defined by department rule; or

(ii) a disabled individual, as defined by department rule;

(b) is not a covered provider; and

(c) is not a licensed health care facility within the state.

(5) "Covered individual":

(a) means an individual:

(i) whom a covered body engages; and

(ii) who may have direct patient access;

(b) includes:

(i) a nursing assistant, as defined by department rule;

(ii) a personal care aide, as defined by department rule;

(iii) an individual licensed to engage in the practice of nursing under Title 58, Chapter 31b, Nurse Practice Act;

(iv) a provider of medical, therapeutic, or social services, including a provider of laboratory and radiology services;

(v) an executive;

(vi) administrative staff, including a manager or other administrator;

(vii) dietary and food service staff;

(viii) housekeeping and maintenance staff; and

(ix) any other individual, as defined by department rule, who has direct patient access; and

(c) does not include a student, as defined by department rule, directly supervised by a member of the staff of the covered body or the student's instructor.

(6) "Covered provider" means:

(a) an end stage renal disease facility;

(b) a long-term care hospital;

(c) a nursing care facility;

(d) a small health care facility;

(e) an assisted living facility;

(f) a hospice;

(g) a home health agency; or

(h) a personal care agency.

(7) "Direct patient access" means for an individual to be in a position where the individual could, in relation to a patient or resident of the covered body who engages the individual:

(a) cause physical or mental harm;

(b) commit theft; or

(c) view medical or financial records.

(8) "Engage" means to obtain one's services:

(a) by employment;

(b) by contract;

(c) as a volunteer; or

(d) by other arrangement.

(9) "Long-term care hospital":

(a) means a hospital that is certified to provide long-term care services under the provisions of 42 U.S.C. Sec. 1395tt; and

(b) does not include a critical access hospital, designated under 42 U.S.C. Sec. 1395i-4(c)(2).

(10) "Patient" means an individual who receives health care services from one of the following covered providers:

(a) an end stage renal disease facility;

(b) a long-term care hospital;

(c) a hospice;

(d) a home health agency; or

(e) a personal care agency.

(11) "Personal care agency" means a health care facility defined by department rule.

(12) "Resident" means an individual who receives health care services from one of the following covered providers:

(a) a nursing care facility;

(b) a small health care facility;

(c) an assisted living facility; or

(d) a hospice that provides living quarters as part of its services.

(13) "Residential setting" means a place provided by a covered provider:

(a) for residents to live as part of the services provided by the covered provider; and

(b) where an individual who is not a resident also lives.

(14) "Volunteer" means an individual, as defined by department rule, who provides services without pay or other compensation.

Enacted by Chapter 328, 2012 General Session

26-21-202. Clearance required.

(1) A covered provider may engage a covered individual only if the individual has clearance.

(2) A covered contractor may supply a covered individual to a covered employer or covered provider only if the individual has clearance.

(3) A covered employer may engage a covered individual who does not have clearance.

(4) (a) Notwithstanding Subsections (1) and (2), if a covered individual does not have clearance, a covered provider may engage the individual or a covered contractor may supply the individual to a covered provider or covered employer:

(i) under circumstances specified by department rule; and

(ii) only while an application for clearance for the individual is pending.

(b) For purposes of Subsection (4)(a), an application is pending if the following have been submitted to the department for the individual:

(i) an application for clearance;

(ii) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and

(iii) any fees established by the department under Subsection 26-21-204(9).

Enacted by Chapter 328, 2012 General Session

26-21-203. Department authorized to grant, deny, or revoke clearance -- Department may limit direct patient access.

(1) As provided in Section 26-21-204, the department may grant, deny, or revoke clearance for an individual, including a covered individual.

(2) The department may limit the circumstances under which a covered individual granted clearance may have direct patient access, based on the relationship the factors under Subsection 26-21-204(4)(a) and other mitigating factors may have to patient and resident protection.

Enacted by Chapter 328, 2012 General Session

26-21-204. Clearance.

(1) The department shall determine whether to grant clearance for each applicant for whom it receives:

(a) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and

(b) any fees established by the department under Subsection 26-21-204(9).

(2) The department shall establish a procedure for obtaining and evaluating relevant information concerning covered individuals, including fingerprinting the applicant and submitting the prints to the Criminal Investigations and Technical Services Division of the Department of Public Safety for checking against applicable state, regional, and national criminal records files.

(3) The department may review the following sources to determine whether an individual should be granted or retain clearance, which may include:

(a) Department of Public Safety arrest, conviction, and disposition records described in Title 53, Chapter 10, Criminal Investigations and Technical Services Act, including information in state, regional, and national records files;

(b) juvenile court arrest, adjudication, and disposition records, as allowed under Section 78A-6-209;

(c) federal criminal background databases available to the state;

(d) the Department of Human Services' Division of Child and Family Services Licensing Information System described in Section 62A-4a-1006;

(e) child abuse or neglect findings described in Section 78A-6-323;

(f) the Department of Human Services' Division of Aging and Adult Services vulnerable adult abuse, neglect, or exploitation database described in Section 62A-3-311.1;

(g) registries of nurse aids described in 42 C.F.R. Sec. 483.156;

(h) licensing and certification records of individuals licensed or certified by the Division of Occupational and Professional Licensing under Title 58, Occupations and Professions; and

(i) the List of Excluded Individuals and Entities database maintained by the United States Department of Health and Human Services' Office of Inspector General.

(4) The department shall adopt rules that:

(a) specify the criteria the department will use to determine whether an individual is granted or retains clearance:

(i) based on an initial evaluation and ongoing review of information under Subsection (3); and

(ii) including consideration of the relationship the following may have to patient and resident protection:

(A) warrants for arrest;

(B) arrests;

(C) convictions, including pleas in abeyance;

(D) pending diversion agreements;

(E) adjudications by a juvenile court of committing an act that if committed by an adult would be a felony or misdemeanor, if the individual is over 28 years of age and has been convicted, has pleaded no contest, or is subject to a plea in abeyance or diversion agreement for a felony or misdemeanor, or the individual is under 28 years of age; and

(F) any other findings under Subsection (3); and

(b) specify the personal identification information that must be submitted by an individual or covered body with an application for clearance, including:

(i) the applicant's Social Security number; and

(ii) except for applicants under 18 years of age, fingerprints.

(5) For purposes of Subsection (4)(a), the department shall classify a crime committed in another state according to the closest matching crime under Utah law, regardless of how the crime is classified in the state where the crime was committed.

(6) The Department of Public Safety, the Administrative Office of the Courts, the Department of Human Services, the Division of Occupational and Professional Licensing, and any other state agency or political subdivision of the state:

(a) shall allow the department to review the information the department may review under Subsection (3); and

(b) except for the Department of Public Safety, may not charge the department for access to the information.

(7) The department shall adopt measures to protect the security of the information it reviews under Subsection (3) and strictly limit access to the information to department employees responsible for processing an application for clearance.

(8) The department may disclose personal identification information specified under Subsection (4)(b) to the Department of Human Services to verify that the subject of the information is not identified as a perpetrator or offender in the information sources described in Subsections (3)(d) through (f).

(9) The department may establish fees, in accordance with Section 63J-1-504, for an application for clearance, which may include:

(a) the cost of obtaining and reviewing information under Subsection (3);

(b) a portion of the cost of creating and maintaining the Direct Access Clearance System database under Section 26-21-209; and

(c) other department costs related to the processing of the application and the ongoing review of information pursuant to Subsection (4)(a) to determine whether clearance should be retained.

Enacted by Chapter 328, 2012 General Session

26-21-205. Department of Public Safety -- Retention of information -- Notification of Department of Health.

The Criminal Investigations and Technical Services Division within the Department of Public Safety shall:

(1) retain, separate from other division records, personal information, including any fingerprints, sent to it by the Department of Health pursuant to Subsection 26-21-204(3)(a); and

(2) notify the Department of Health upon receiving notice that an individual for whom personal information has been retained is the subject of:

(a) a warrant for arrest;

(b) an arrest;

(c) a conviction, including a plea in abeyance; or

(d) a pending diversion agreement.

Enacted by Chapter 328, 2012 General Session

26-21-206. Covered providers and covered contractors required to apply for clearance of certain individuals.

(1) As provided in Subsection (2), each covered provider and covered contractor operating in this state shall:

(a) collect from each covered individual it engages, and each individual it intends to engage as a covered individual, the personal identification information specified by the department under Subsection 26-21-204(4)(b); and

(b) submit to the department an application for clearance for the individual, including:

(i) the personal identification information; and

(ii) any fees established by the department under Subsection 26-21-204(9).

(2) Clearance granted for an individual pursuant to an application submitted by a covered provider or a covered contractor is valid until the later of:

(a) two years after the individual is no longer engaged as a covered individual; or

(b) the covered provider's or covered contractor's next license renewal date.

Enacted by Chapter 328, 2012 General Session

26-21-207. Covered providers required to apply for clearance for certain individuals other than residents residing in residential settings -- Certain individuals other than residents prohibited from residing in residential settings

without clearance.

(1) A covered provider that provides services in a residential setting shall:

(a) collect the personal identification information specified by the department under Subsection 26-21-204(4)(b) for each individual 12 years of age or older, other than a resident, who resides in the residential setting; and

(b) submit to the department an application for clearance for the individual, including:

(i) the personal identification information; and

(ii) any fees established by the department under Subsection 26-21-204(9).

(2) A covered provider that provides services in a residential setting may allow an individual 12 years of age or older, other than a resident, to reside in the residential setting only if the individual has clearance.

Enacted by Chapter 328, 2012 General Session

26-21-208. Application for clearance by individuals.

(1) An individual may apply for clearance by submitting to the department an application, including:

(a) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and

(b) any fees established by the department under Subsection 26-21-204(9).

(2) Clearance granted to an individual who makes application under Subsection (1) is valid for two years unless the department determines otherwise based on its ongoing review under Subsection 26-21-204(4)(a).

Enacted by Chapter 328, 2012 General Session

26-21-209. Direct Access database -- Contents -- Use.

(1) The department shall create and maintain a Direct Access Clearance System database, which:

(a) includes the names of individuals for whom the department has received an application for clearance; and

(b) indicates for each applicant whether an application is pending and whether clearance has been granted and retained.

(2) (a) The department shall allow covered providers and covered contractors to access the database electronically.

(b) Data accessible to a covered provider or covered contractor is limited to the information under Subsection (1) for:

(i) covered individuals engaged by the covered provider or covered contractor; and

(ii) individuals:

(A) whom the covered provider or covered contractor could engage as covered individuals; and

(B) who have provided the covered provider or covered contractor with sufficient personal identification information to uniquely identify the individual in the database.

(c) (i) The department may establish fees, in accordance with Section

63J-1-504, for use of the database by a covered contractor.

(ii) The fees may include, in addition to any fees established by the department under Subsection 26-21-204(9), an initial set-up fee, an ongoing access fee, and a per-use fee.

Enacted by Chapter 328, 2012 General Session

26-21-210. No civil liability.

A covered body is not civilly liable for submitting to the department information required under this part or refusing to employ an individual who does not have clearance to have direct patient access under Section 26-21-203.

Enacted by Chapter 328, 2012 General Session